COST SHARING AMOUNTS DESCRIBE THE ENROLLEE'S OUT OF POCKET COSTS	Platinum Coinsurance Plan	Platinum Copay Plan
7/18/2013		
Actuarial Value - Final AV Calculator	88.1%	88.0%
Overall deductible	\$0	\$0
Other deductibles for specific services		
Medical	\$0	\$0
Brand Drugs	\$0	\$0
Dental	See attachment	See attachment
Out-of-pocket limit on expenses	\$4,000	\$4,000

Out-of-pocket limit on expenses		\$4,00	\$4,000		\$4,000	
Common Medical		Member Cost	Deductible	Member Cost	Deductible	
Event	Service Type	Share	Applies	Share	Applies	
isit to a health	Primary care visit to treat an injury or illne footnote)	ess (see \$20		\$20		
ffice or clinic	Specialist visit	\$40	-	\$40		
ince or cirric	Other practitioner office visit	\$20	Į	\$20		
Pre	Preventive care/ screening/ immunization			No cost share		
	Laboratory Tests	\$20		\$20		
ests	X-rays and Diagnostic Imaging	\$40		\$40		
esis	Imaging (CT/PET scans, MRIs)	10%	-	\$150		
	Generic drugs	\$5		\$150		
rugs to treat	Preferred brand drugs	\$15		\$15		
lness or	Non-preferred brand drugs			\$25		
ondition		\$25 10%				
	Specialty drugs			10%		
utpatient	Facility fee (e.g., ASC)	10%	-	\$250		
urgery	Physician/surgeon fees	10%		0450		
	Emergency room services (waived if adm	45-45-45-45-45-45-45-45-45-45-45-45-45-4	-	\$150		
	Emergency medical transportation	\$150		\$150		
leed immediate ttention	Urgent care	\$40		\$40		
	Facility fee (e.g., hospital room)	10%		\$250 per day up		
ospital stay	Physician/surgeon fee	10%		to 5 days		
	Mental/Behavioral health outpatient servi	ices \$20		\$20		
lental health, ehavioral health,	Mental/Behavioral health inpatient servic	es 10%		\$250 per day up to 5 days		
or substance abuse needs	Substance use disorder outpatient service	ces \$20		\$20		
	Substance use disorder inpatient service	es 10%		\$250 per day up to 5 days		
	Prenatal care and preconception visits	No cost share		No cost share		
regnancy	Delivery and all inpatient Hospital	10%		\$250 per day up		
	services Professi	onal 10%	Que established	to 5 days		
	Home health care	10%	OLIVE CONTRACTOR OF THE PARTY O	\$20		
	Rehabilitation services	\$20		\$20		
elp recovering	Habilitation services	\$20	1	\$20		
r other special				\$150 per day up		
health needs Skilled nursing care		10%		to 5 days		
	Durable medical equipment	10%	1	10%		
	Hospice service	No cost share	De la companya de la	No cost share		
	Eye exam (deductible waived)	0%		0%		
hild needs	Glasses	1 pair per year	1	1 pair per year		
lental or eye care	Dental check-up - Preventive and Diagno Dental Basic Services	Pediatric Dent		Pediatric Denta		
	Dental Restorative and Orthodontia Serv	rices Plan Design	attached	Plan Design	attached	

Notes:

²⁾ Cost sharing amounts for all in-network services accumulate toward the maximum out-of-pocket expense.

³⁾ Cost sharing for services with copayments is the lesser of the copayment amount or allowed amount.

⁴⁾ For the Bronze and Catastrophic plans, deductible is waived for three office or urgent care visits, including outpatient Mental Health/Substance Abuse visits.

^{5) &}quot;Other Practitioner Office Visits" includes Therapy Visits, other office visits not provided by either Primary Care or Specialty Physicians or not specified in another benefit category.

COST SHARING AMOUNTS DESCRIBE THE ENROLLEE'S OUT OF POCKET COSTS	Gold Coinsurance Plan	Gold Copay Plan		
7/18/2013		3 1 2 4 1 1 1 1 1 1 7 1 3 3 3 1 1 1 1 1 1 2 1 1 2		
Actuarial Value - Final AV Calculator	78.3%	78.8%		
Overall deductible	\$0	\$0		
Other deductibles for specific services				
Medical	\$0	\$0		
Brand Drugs	\$0	\$0		
Dental	See attachment	See attachment		
Out-of-pocket limit on expenses	\$6,350	\$6,350		
	THE RESERVE AND ADDRESS OF THE PERSON NAMED IN COLUMN 1	Market Ma		

Out-of-pocket lim	t on expenses		\$6,350		\$6,350	
Common Medical			Member Cost	Deductible	Member Cost	Deductible
Event	Service 1	ype	Share	Applies	Share	Applies
/isit to a health	Primary care visit to treat an injury or illness (see footnote)		\$30	mak, erricefringer Apademikking man	\$30	
office or clinic	Specialist visit		\$50	<u> </u>	\$50	
	Other practitioner office visit		\$30		\$30	
	Preventive care/ screening/ i	mmunization	No cost share		No cost share	
	Laboratory Tests		\$30		\$30	
ests	X-rays and Diagnostic Imagin	na	\$50	}	\$50	
	Imaging (CT/PET scans, MR		20%	-	\$250	
	Generic drugs	10)	\$19	-	\$19	
rugs to treat	Preferred brand drugs		\$50		\$50	
Iness or	Non-preferred brand drugs		\$70	ļ	\$70	
ondition	Specialty drugs		CONTRACTOR OF THE PROPERTY OF		Commence of the Commence of th	
tmatlant			20%		20%	
utpatient	Facility fee (e.g., ASC)		20%		\$600	
urgery	Physician/surgeon fees		20%	ļ	0050	
	Emergency room services (w		\$250	ļ	\$250	
	Emergency medical transpor	tation	\$250	<u></u>	\$250	
Need immediate attention Urgent care			\$60	B. CT. STEEL CO. CA. CA. CA. CA. CA. CA. CA. CA. CA. CA	\$60	
	Facility fee (e.g., hospital room)		20%		\$600 per day up	
lospital stay	Physician/surgeon fee		20%	1	to 5 days	
	Mental/Behavioral health outpatient services		\$30		\$30	
flental health, ehavioral health,	Mental/Behavioral health inp	atient services	20%		\$600 per day up to 5 days	
or substance abuse needs	Substance use disorder outpatient services		\$30		\$30	
	Substance use disorder inpa	tient services	20%		\$600 per day up to 5 days	
	Prenatal care and preconcep	otion visits	No cost share	ē.	No cost share	
regnancy	Delivery and all inpatient	Hospital	20%	1	\$600 per day up	
	services	Professional	20%		to 5 days	
	Home health care		20%	Į.	\$30	
	Rehabilitation services	***************************************	\$30	1	\$30	
lelp recovering	Habilitation services		\$30	1	\$30	
or other special health needs	Skilled nursing care		20%		\$300 per day up to 5 days	
	Durable medical equipment		20%	1	20%	
	Hospice service	······································	No cost share	1	No cost share	
	Eye exam (deductible waive	4)	0%	-	0%	
	Glasses	4)				
Child needs		and Diagnostic	1 pair per year	1	1 pair per year	l
lental or eye care	Dental Basic Services		Pediatric Denta Plan Design		Pediatric Denta Plan Design	
	Dental Restorative and Ortho	odontia Services			L	

Notes

¹⁾ Family deductibles and out-of-pocket maximums are equal to 2 times the individual values. Except for high deductible health plans (HDHPs) linked to Health Savings Accounts (HSAs),in a family plan, an individual is responsible only for the single out-of-pocket deductible and a single out of pocket maximum amount. Deductibles and other cost sharing payments made by each individual in a family contribute to the family deductible or out of pocket maximum. Once the family deductible amount is satisfied by any combination of individual deductible payments, plan copays or coinsurance apply until the family out of pocket maximum is reached, after which the plan pays all costs for covered services for all family members. Under HDHP plans, the family deductible must be satisfied before the plan pays anything for services for any individual in the family, and the family out-of-pocket maximum must be satisfied before any individual's cost sharing responsibility ends.

²⁾ Cost sharing amounts for all in-network services accumulate toward the maximum out-of-pocket expense.

³⁾ Cost sharing for services with copayments is the lesser of the copayment amount or allowed amount.

⁴⁾ For the Bronze and Catastrophic plans, deductible is waived for three office or urgent care visits, including outpatient Mental Health/Substance Abuse visits.
5) "Other Practitioner Office Visits" includes Therapy Visits, other office visits not provided by either Primary Care or Specialty Physicians or not specified in another

benefit category.

Covered California Standard Benefit Plan Designs - FINAL

Summary of Benefits and Coverage	Individual	Individual
COST SHARING AMOUNTS DESCRIBE THE ENROLLEE'S OUT OF POCKET COSTS	Silver Coinsurance Plan	Silver Copay Plan
7/18/2013		
Actuarial Value - Final AV Calculator	69.7%	69.2%
Overall deductible	N/A	N/A
Other deductibles for specific services		
Medical	\$2,000	\$2,000
Brand Drugs	\$250	\$250
Dental	See attachment	See attachment
Out-of-pocket limit on expenses	\$6,350	\$6,350

Out-of-pocket limit on expenses		\$6,35	\$6,350		\$6,350	
Common Medical		Member Cost	Deductible	Member Cost	Deductible	
Event	Service Type	Share	Applies	Share	Applies	
Visit to a health care provider's	Primary care visit to treat an injury or illness footnote)	(see \$45		\$45		
office or clinic	Specialist visit	\$65		\$65		
	Other practitioner office visit	\$45	1	\$45		
	Preventive care/ screening/ immunization	No cost share		No cost share		
	Laboratory Tests	\$45		\$45		
ests	X-rays and Diagnostic Imaging	\$65	ĺ	\$65		
	Imaging (CT/PET scans, MRIs)	20%	Х	\$250		
	Generic drugs	\$19		\$19		
rugs to treat Iness or	Preferred brand drugs	\$50	Х	\$50	Х	
ondition	Non-preferred brand drugs	\$70	Х	\$70	Х	
ondition	Specialty drugs	20%	Х	20%	X	
Outpatient	Facility fee (e.g., ASC)	20%	-	20%		
urgery	Physician/surgeon fees	20%	1	20%		
	Emergency room services (waived if admitte	d) \$250	X	\$250	Х	
	Emergency medical transportation	\$250	X	\$250	Х	
leed immediate attention	Urgent care	\$90		\$90		
loonital atou	Facility fee (e.g., hospital room)	20%	Х	20%	Х	
lospital stay	Physician/surgeon fee	20%		20%	^	
	Mental/Behavioral health outpatient services	\$45	giniting professional experiments	\$45		
Mental health, behavioral health,	Mental/Behavioral health inpatient services	20%	Х	20%	Х	
or substance abuse needs				\$45		
	Substance use disorder inpatient services	20%	Х	20%	Х	
	Prenatal care and preconception visits	No cost share	The second secon	No cost share		
regnancy	Delivery and all inpatient Hospital	20%	Х	20%	Х	
	services Professiona	20%		2076	^	
	Home health care	20%	Orthodox	\$45		
	Rehabilitation services	\$45	- Company	\$45		
lelp recovering	Habilitation services	\$45	-	\$45	1	
r other special ealth needs	special Skilled nursing care		Х	20%	х	
	Durable medical equipment	20%	La constitue de la constitue d	20%		
	Hospice service	No cost share		No cost share		
	Eye exam (deductible waived)	0%	9	0%		
bild poods	Glasses	1 pair per year	1	1 pair per year		
Child needs lental or eye care	Dental check-up - Preventive and Diagnostic Dental Basic Services Dental Restorative and Orthodontia Services	Pediatric Denta		Pediatric Dental Standard		

Notes

²⁾ Cost sharing amounts for all in-network services accumulate toward the maximum out-of-pocket expense.

³⁾ Cost sharing for services with copayments is the lesser of the copayment amount or allowed amount.

⁴⁾ For the Bronze and Catastrophic plans, deductible is waived for three office or urgent care visits, including outpatient Mental Health/Substance Abuse visits.

^{5) &}quot;Other Practitioner Office Visits" includes Therapy Visits, other office visits not provided by either Primary Care or Specialty Physicians or not specified in another benefit category.

Covered California Standard Benefit Plan Designs - FINAL

Summary of Benefits and Coverage	SHOP	SHOP
COST SHARING AMOUNTS DESCRIBE THE ENROLLEE'S OUT OF POCKET COSTS	Silver Coinsurance Plan	Silver Copay Plan
7/18/2013		
Actuarial Value - Final AV Calculator	70.7%	70.3%
Overall deductible	N/A	N/A
Other deductibles for specific services		
Medical	\$1,500	\$1,500
Brand Drugs	\$500	\$500
Dental	See attachment	See attachment
Out-of-pocket limit on expenses	\$6,350	\$6,350

Out-of-pocket limit on expenses		\$6,35	0	\$6,350		
Common Medical Event	Service 1	Гуре	Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies
/isit to a health	Primary care visit to treat an footnote)	injury or illness (see	\$45		\$45	
office or clinic	Specialist visit		\$65		\$65	<u></u>
ince or clinic	Other practitioner office visit	*******************************	\$45		\$45	
	Preventive care/ screening/		No cost share	<u></u>	No cost share	}
	Laboratory Tests	minumzation	\$45		\$45	
ests	X-rays and Diagnostic Imagi	na	\$65		\$65	
esis	Imaging (CT/PET scans, MR		20%	X	\$250	
	Generic drugs	.15)	\$19	^	\$19	
rugs to treat	Preferred brand drugs		\$50	X	\$50	Х
ness or	Non-preferred brand drugs		\$70	X	\$70	X
ondition	Specialty drugs		20%	X	20%	X
utpatient	Facility fee (e.g., ASC)		20%	^	20%	^
	Physician/surgeon fees		20%		20%	
urgery	Emergency room services (v	unived if admitted)				
			\$250	X	\$250	X
eed immediate	Emergency medical transpo	tation	\$250		\$250	
ttention	Urgent care		\$90		\$90	
lospital stay	Facility fee (e.g., hospital room)		20%	Х	20%	Х
oopital stay	Physician/surgeon fee		20%		2070	
	Mental/Behavioral health ou	tpatient services	\$45		\$45	Calming A. Displacement of the Control
Mental health, ehavioral health,	Mental/Behavioral health inp	atient services	20%	х	20%	Х
or substance buse needs	Substance use disorder outp	patient services	\$45		\$45	Or summarian and or sum
	Substance use disorder inpa	atient services	20%	Х	20%	х
	Prenatal care and preconce	otion visits	No cost share	\$	No cost share	1
regnancy	Delivery and all inpatient	Hospital	20%	Х		· ·
	services	Professional	20%		20%	Х
	Home health care		20%		\$45	
	Rehabilitation services		\$45		\$45	
elp recovering	Habilitation services	***************************************	\$45		\$45	1
r other special	Skilled nursing care Durable medical equipment		20%	Х	20%	X
ealth needs			20%		20%	
	Hospice service		No cost share		No cost share	1
	Eye exam (deductible waive	d)	0%	1	0%	1
	Glasses	<u> </u>		<u> </u>	S	
hild needs	Dental check-up - Preventive	and Diagnostic	1 pair per year	l	1 pair per year	1
lental or eye care	Dental Basic Services Dental Restorative and Orthor		Pediatric Denta Plan Design		Pediatric Denta Plan Design	

Notes:

²⁾ Cost sharing amounts for all in-network services accumulate toward the maximum out-of-pocket expense.

³⁾ Cost sharing for services with copayments is the lesser of the copayment amount or allowed amount.

⁴⁾ For the Bronze and Catastrophic plans, deductible is waived for three office or urgent care visits, including outpatient Mental Health/Substance Abuse visits.

^{5) &}quot;Other Practitioner Office Visits" includes Therapy Visits, other office visits not provided by either Primary Care or Specialty Physicians or not specified in another benefit category.

Covered California Standard Benefit Plan Designs - FINAL

Summary of Benefits and Coverage	SHOP
COST SHARING AMOUNTS DESCRIBE THE ENROLLEE'S OUT OF POCKET COSTS	Silver HSA Plan
7/18/2013	
Actuarial Value - Final AV Calculator	71.5%
Overall deductible	\$1,500 integrated Med/Rx
Other deductibles for specific services	
Medical	N/A
Brand Drugs	N/A
Dental	See attachment
Out-of-pocket limit on expenses	\$6,350

Common Medical Event	Service Ty	rpe	Member Cost Share	Deductible Applies
Visit to a health care provider's	Primary care visit to treat an ir footnote)		20%	x
office or clinic	Specialist visit		20%	X
	Other practitioner office visit		20%	Х
	Preventive care/ screening/ im	munization	No cost share	
	Laboratory Tests		20%	Х
Tests	X-rays and Diagnostic Imaging	3	20%	Х
	Imaging (CT/PET scans, MRIs	5)	20%	Х
	Generic drugs		20%	Х
Drugs to treat	Preferred brand drugs		20%	Х
illness or	Non-preferred brand drugs		20%	X
condition	Specialty drugs		20%	X
Outpatient	Facility fee (e.g., ASC)		20%	X
surgery	Physician/surgeon fees		20%	X
Surgery	Emergency room services (wa	ived if admitted)	20%	X
	Emergency medical transporta		20%	X
Need immediate attention	Urgent care	2001	20%	x
	Facility fee (e.g., hospital room)		20%	X
Hospital stay	Physician/surgeon fee		20%	X
Mental health,	Mental/Behavioral health outp		20%	X
behavioral health, or substance abuse needs	Mental/Behavioral health inpatient services Substance use disorder outpatient services		20%	x
	Substance use disorder inpati	ent services	20%	Х
	Prenatal care and preconcept	ion visits	No cost share	
Pregnancy	Delivery and all inpatient	Hospital	20%	Х
	services	Professional	20%	X
	Home health care		20%	Х
	Rehabilitation services		20%	X
Help recovering	Habilitation services		20%	X
or other special health needs	Skilled nursing care		20%	Х
	Durable medical equipment		20%	Х
	Hospice service		No cost share	X
	Eye exam (deductible waived	1	0%	^
	Glasses)	V	
Child needs		and Diagnostic	1 pair per year	l
dental or eye care	Dental Check-up - Preventive Dental Basic Services	Pediatric Dental Standard Plan Design attached		
	Dental Restorative and Orthod	iontia Services	Lamesan	

Notes:

¹⁾ Family deductibles and out-of-pocket maximums are equal to 2 times the individual values. Except for high deductible health plans (HDHPs) linked to Health Savings Accounts (HSAs), in a family plan, an individual is responsible only for the single out-of-pocket deductible and a single out of pocket maximum amount. Deductibles and other cost sharing payments made by each individual in a family contribute to the family deductible or out of pocket maximum. Once the family deductible amount is satisfied by any combination of individual deductible payments, plan copays or coinsurance apply until the family out of pocket maximum is reached, after which the plan pays all costs for covered services for all family members. Under HDHP plans, the family deductible must be satisfied before the plan pays anything for services for any individual in the family, and the family out-of-pocket maximum must be satisfied before any individual's cost sharing responsibility ends.

²⁾ Cost sharing amounts for all in-network services accumulate toward the maximum out-of-pocket expense.

³⁾ Cost sharing for services with copayments is the lesser of the copayment amount or allowed amount.

⁴⁾ For the Bronze and Catastrophic plans, deductible is waived for three office or urgent care visits, including outpatient Mental Health/Substance Abuse visits.

^{5) &}quot;Other Practitioner Office Visits" includes Therapy Visits, other office visits not provided by either Primary Care or Specialty Physicians or not specified in another benefit category.

COST SHARING AMOUNTS DESCRIBE THE ENROLLEE'S OUT OF POCKET COSTS	Silver Coinsurance Plan 100%-150% FPL	Silver Coinsurance Plan 150%-200% FPL
7/18/2013		
Actuarial Value - Final AV Calculator	94.8%	87.8%
Overall deductible	\$0	N/A
Other deductibles for specific services		
Medical	\$0	\$500
Brand Drugs	\$0	\$50
Dental	See attachment	See attachment
Out-of-pocket limit on expenses	\$2,250	\$2,250
	The state of the s	

Jut-ot-pocket iim	it off expenses		\$2,250		\$2,250	
Common Medical			Member Cost	Deductible	Member Cost	Deductible
Event	Service T	ype	Share	Applies	Share	Applies
	L a summer a sum a					
	Primary care visit to treat an i	njury or illness (see	\$3		\$15	
isit to a health	footnote)		Ψ		410	
are provider's						
ffice or clinic	Specialist visit		\$5		\$20	
	Other practitioner office visit		\$3		\$15	
	Preventive care/ screening/ in	nmunization	No cost share		No cost share	
	Laboratory Tests		\$3		\$15	
ests	X-rays and Diagnostic Imagin		\$5		\$20	
	Imaging (CT/PET scans, MRI	s)	10%		15%	Х
rugs to treat	Generic drugs		\$3		\$5	
Iness or	Preferred brand drugs		\$5		\$15	Х
ondition	Non-preferred brand drugs		\$10		\$25	Х
ondition	Specialty drugs		10%		15%	Х
outpatient	Facility fee (e.g., ASC)		10%		15%	
urgery	Physician/surgeon fees		10%		15%	
	Emergency room services (wa	aived if admitted)	\$25		\$75	Х
	Emergency medical transport	ation	\$25		\$75	Х
leed immediate						
ttention			200			
	Urgent care		\$6		\$30	
	Facility fee (e.g., hospital room)		10%		15%	Х
lospital stay	Physician/surgeon fee		10%		15%	
	1 Hydrolanical geom lee		1070	-	1070	
	Mental/Behavioral health outp	patient services	\$3		\$15	
Mental health,						
ehavioral health.	Mental/Behavioral health inpa	atient services	10%		15%	Х
r substance			·	<u> </u>		
buse needs						
ibuse neeus	Substance use disorder outpatient services		\$3		\$15	
			-			
	Substance use disorder inpat	tient services	10%		15%	Х
	Prenatal care and preconcep	tion vioito	No cost share		No cost share	
Prognancy						V
Pregnancy	Delivery and all inpatient services	Hospital	10%		15%	X
		Professional	10%	<u></u>	15%	
	Home health care		10%		15%	
	Rehabilitation services		\$3		\$15	
lelp recovering	Habilitation services		\$3	<u> </u>	\$15	
or other special	Skilled nursing care		10%	W4400	15%	Х
health needs	Durable medical equipment					
			10%		15%	
	Hospice service		No cost share		No cost share	
	Eye exam (deductible waived	1)	0%		0%	
hild needs	Glasses		1 pair per year		1 pair per year	
	Dental check-up - Preventive	and Diagnostic	Podietrie Dest	al Ctondard	Podiotrio Donto	ol Ctondo
dental or eye care	Dental Basic Services		Pediatric Denta		Pediatric Denta	
			Plan Design attached		Plan Design attached	

Notes:

²⁾ Cost sharing amounts for all in-network services accumulate toward the maximum out-of-pocket expense.

³⁾ Cost sharing for services with copayments is the lesser of the copayment amount or allowed amount.

⁴⁾ For the Bronze and Catastrophic plans, deductible is waived for three office or urgent care visits, including outpatient Mental Health/Substance Abuse visits.

^{5) &}quot;Other Practitioner Office Visits" includes Therapy Visits, other office visits not provided by either Primary Care or Specialty Physicians or not specified in another benefit category.

Common Medical Event	Service Type	Member Cost Share	Deductible Applies	
Out-of-pocket limit on e	expenses	\$5,20	0	
Dental		See attachment		
Brand Drugs		\$250		
Medi		\$1,500		
Other deductibles for sp	ecific services			
Overall deductible		N/A		
Actuarial Value - Final A	V Calculator	74.0%	6	
7/18/2013				
ENROLLEE'S OUT	OF POCKET COSTS	200%-2509	% FPL	
COST SHARING AMO		Silver Coinsur	ance Plan	

Common Medical			Member Cost	Deductible
Event	Service Ty	pe	Share	Applies
Visit to a health care provider's	Primary care visit to treat an infootnote)	jury or illness (see	\$40	
office or clinic	Specialist visit		\$50	
	Other practitioner office visit		\$40	
	Preventive care/ screening/ im	munization	No cost share	
	Laboratory Tests		\$40	
Tests	X-rays and Diagnostic Imaging		\$50	
	Imaging (CT/PET scans, MRIs)	20%	Х
Drugs to treat	Generic drugs		\$19	
illness or	Preferred brand drugs		\$30	Х
condition	Non-preferred brand drugs		\$50	Х
	Specialty drugs		20%	Х
Outpatient	Facility fee (e.g., ASC)		20%	
surgery	Physician/surgeon fees		20%	
	Emergency room services (wai		\$250	X
	Emergency medical transporta	tion	\$250	X
Need immediate attention Urgent care			\$80	
	Facility fee (e.g., hospital room)	20%	Х
Hospital stay	Physician/surgeon fee	20%		
	Mental/Behavioral health outpa	atient services	\$40	
Mental health, behavioral health,	Mental/Behavioral health inpat	ient services	20%	Х
or substance abuse needs	Substance use disorder outpatient services		\$40	
	Substance use disorder inpatie	ent services	20%	Х
	Prenatal care and preconception	MI/MOVEMENT AND ADDRESS OF THE PARTY OF THE	No cost share	
Pregnancy	Delivery and all inpatient	Hospital	20%	X
	services	Professional	20%	
	Home health care		20%	
	Rehabilitation services		\$40	
Help recovering	Habilitation services		\$40	
or other special health needs	Skilled nursing care		20%	х
	Durable medical equipment		20%	WW.
	Hospice service		No cost share	
	Eye exam (deductible waived)	Section 4	0%	
Child needs	Glasses		1 pair per year	
dental or eye care	Dental check-up - Preventive a	and Diagnostic	Pediatria Danta	ol Standard
dental of eye care	Dental Basic Services		Pediatric Dental Standard	
		Restorative and Orthodontia Services Plan Design		

Notes

²⁾ Cost sharing amounts for all in-network services accumulate toward the maximum out-of-pocket expense.

³⁾ Cost sharing for services with copayments is the lesser of the copayment amount or allowed amount.

⁴⁾ For the Bronze and Catastrophic plans, deductible is waived for three office or urgent care visits, including outpatient Mental Health/Substance Abuse visits.

^{5) &}quot;Other Practitioner Office Visits" includes Therapy Visits, other office visits not provided by either Primary Care or Specialty Physicians or not specified in another benefit category.

	AND THE RESIDENCE OF THE PARTY	
COST SHARING AMOUNTS DESCRIBE THE ENROLLEE'S OUT OF POCKET COSTS	Silver Copay Plan 100%-150% FPL	Silver Copay Plan 150%-200% FPL
7/18/2013	SECTION AND SECTION	
Actuarial Value - Final AV Calculator	94.9%	87.8%
Overall deductible	\$0	N/A
Other deductibles for specific services		
Medical	\$0	\$500
Brand Drugs	\$0	\$50
Dental	See attachment	See attachment
Out-of-pocket limit on expenses	\$2,250	\$2,250
	3	

	t mint on expenses			Ψ2,230		Ψ2,200	
Common Medical			Member Cost	Deductible	Member Cost	Deductible	
Event	Service T	ype	Share	Applies	Share	Applies	
	Discourse						
/:=:4.4= = b==14b	Primary care visit to treat an	injury or lliness (see	\$3		\$15		
isit to a health are provider's	footnote)						
ffice or clinic	Specialist visit		\$5		\$20		
ince or clinic	Other practitioner office visit		\$3		\$20 \$15		
	Preventive care/ screening/ in	mmunization	No cost share	3	No cost share		
	Laboratory Tests	minumzation	\$3		\$15		
ests	X-rays and Diagnostic Imagir	na	\$5		\$20		
Coto	Imaging (CT/PET scans, MR		\$50		\$100		
	Generic drugs	10)	\$3		\$5		
rugs to treat	Preferred brand drugs		\$5		\$15	Х	
ness or	Non-preferred brand drugs	***************************************	\$10		\$25	X	
ondition	Specialty drugs		10%		15%	X	
utpatient	Facility fee (e.g., ASC)		10%		15%	^_	
urgery	Physician/surgeon fees		10%		15%		
urgery	Emergency room services (w	vaived if admitted)	\$25		\$75	Х	
	Emergency medical transpor		\$25		\$75	X	
eed immediate	Emergency medical transpor	lation	φΖΟ		\$15	^	
ttention							
tterition	Urgent care		\$6		\$30		
			No.				
	Facility fee (e.g., hospital roo	ım)	-				
ospital stay	Physician/surgeon fee	111)	10%		15%	Х	
	r nysician/surgeon lee		-				
			Southern				
Mental/Behavioral health ou	atient services	\$3		\$15			
lental health,				ļ			
ehavioral health,	Mental/Behavioral health inpatient services		10%		15%	X	
r substance			-		5		
buse needs	0000 00 1360 0000 NO		essection				
buse needs	Substance use disorder outpatient services		\$3		\$15		
			-				
	Substance use disorder inpa	tient services	10%		15%	Х	
	Prenatal care and preconcep	tion visits	No cost share		No cost share		
regnancy	Delivery and all inpatient	Hospital		<u> </u>			
	services	Professional	10%		15%	Х	
	Home health care	i roicssionai	\$3		\$15		
	Rehabilitation services		\$3		\$15		
elp recovering	Habilitation services		\$3		\$15		
r other special			φυ		φισ		
ealth needs	Skilled nursing care		10%		15%	Х	
outer nocuo	Durable medical equipment		10%	<u> </u>	15%		
	Hospice service		No cost share		No cost share		
	Eye exam (deductible waived	41	0%	ļ			
	Glasses	.)		3	0%		
hild needs		and Diagnostic	1 pair per year	l	1 pair per year	L	
ental or eye care	Dental check-up - Preventive Dental Basic Services	and Diagnostic	Pediatric Denta	al Standard	Pediatric Denta	al Standard	
		destis Con '	Plan Design		Plan Design		
	Dental Restorative and Ortho	odontia Services	I lair booign attached		1		

Notes

²⁾ Cost sharing amounts for all in-network services accumulate toward the maximum out-of-pocket expense.

³⁾ Cost sharing for services with copayments is the lesser of the copayment amount or allowed amount.

⁴⁾ For the Bronze and Catastrophic plans, deductible is waived for three office or urgent care visits, including outpatient Mental Health/Substance Abuse visits.

^{5) &}quot;Other Practitioner Office Visits" includes Therapy Visits, other office visits not provided by either Primary Care or Specialty Physicians or not specified in another benefit category.

7/18/2013				
AND DESCRIPTION OF THE PROPERTY OF THE PROPERT	Final AV Calculator		73.6%	, 0
Overall deductible			N/A	
	for specific services		IWA	
	Medical		\$1,50	0
	Brand Drugs		\$250	
	Dental		See attach	
Out-of-pocket lin	nit on expenses		\$5,20	0
Common Medical Event	Service Type		Member Cost Share	Deductibl Applies
				BH BENGAL SAL SANSANSAN
	Primary care visit to treat an	injury or illness (see	\$40	
Visit to a health	footnote)		1	
care provider's office or clinic	Specialist visit		¢F0	
onice or clinic	Specialist visit		\$50	
	Other practitioner office visit	mmunization	\$40	
	Preventive care/ screening/ i	mmunization	No cost share	
Toolo	Laboratory Tests		\$40	
Tests	X-rays and Diagnostic Imagii		\$50	
	Imaging (CT/PET scans, MR	is)	\$250	
Orugs to treat	Generic drugs		\$19	
liness or	Preferred brand drugs		\$30	X
condition	Non-preferred brand drugs		\$50	Х
	Specialty drugs		20%	Х
Outpatient	Facility fee (e.g., ASC)		20%	
surgery	Physician/surgeon fees		20%	
	Emergency room services (w		\$250	Х
	Emergency medical transpor	tation	\$250	X
Need immediate attention	Urgent care		\$80	
	Facility fee (e.g., hospital roo	om)		
Hospital stay	Physician/surgeon fee		20%	Х
	Mental/Behavioral health out	Mental/Behavioral health outpatient services		
Mental health, behavioral health	Mental/Behavioral health inp	atient services	20%	Х
or substance abuse needs	Substance use disorder outp	atient services	\$40	
	Substance use disorder inpa		20%	Х
	Prenatal care and preconcer		No cost share	
Pregnancy	Delivery and all inpatient	Hospital	20%	Х
	services	Professional		
	Home health care		\$40	
	Rehabilitation services		\$40	
Help recovering	Habilitation services		\$40	
or other special nealth needs	Skilled nursing care		20%	Х
	Durable medical equipment		20%	
	Hospice service	***************************************	No cost share	
	Eye exam (deductible waive	d)	0%	
	Glasses		1 pair per year	
Child needs			, pan por jour	
dental or eye care	Dental check-up - Preventive and Diagnostic Dental Basic Services		 Pediatric Denta 	

Notes:

Plan Design attached

Dental Restorative and Orthodontia Services

¹⁾ Family deductibles and out-of-pocket maximums are equal to 2 times the individual values. Except for high deductible health plans (HDHPs) linked to Health Savings Accounts (HSAs), in a family plan, an individual is responsible only for the single out-of-pocket deductible and a single out of pocket maximum amount. Deductibles and other cost sharing payments made by each individual in a family contribute to the family deductible or out of pocket maximum. Once the family deductible amount is satisfied by any combination of individual deductible payments, plan copays or coinsurance apply until the family out of pocket maximum is reached, after which the plan pays all costs for covered services for all family members. Under HDHP plans, the family deductible must be satisfied before the plan pays anything for services for any individual in the family, and the family out-of-pocket maximum must be satisfied before any individual's cost sharing responsibility ends.

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^{5) &}quot;Other Practitioner Office Visits" includes Therapy Visits, other office visits not provided by either Primary Care or Specialty Physicians or not specified in another

COST SHARING AMOUNTS DESCRIBE THE ENROLLEE'S OUT OF POCKET COSTS	Bronze Plan	Bronze HSA Plan
7/18/2013		
Actuarial Value - Final AV Calculator	60.5%	59.0%
Overall deductible	\$5,000 integrated Med/Rx	\$4,500 integrated Med/Rx
Other deductibles for specific services		-
Medical	N/A	N/A
Brand Drugs	N/A	N/A
Dental	See attachment	See attachment
Out-of-pocket limit on expenses	\$6,350	\$6,350

Out-of-pocket lim	it on expenses	\$6,35	\$6,350		0	
Common Medical			Member Cost	Deductible	Member Cost	Deductible
Event	Service 3	Гуре	Share	Applies	Share	Applies
/isit to a health	Primary care visit to treat an footnote)	injury or illness (see	\$60	After 1st 3 non- preventive visits	40%	x
office or clinic	Specialist visit		\$70	X	40%	X
	Other practitioner office visit		\$60	X	40%	X
	Preventive care/ screening/	immunization	No cost share		No cost share	
	Laboratory Tests		30%	X	40%	X
ests	X-rays and Diagnostic Imagi	ng	30%	X	40%	Х
	Imaging (CT/PET scans, MR	ds)	30%	Х	40%	Х
Orugs to treat	Generic drugs		\$19	X	40%	X
liness or	Preferred brand drugs		\$50	X	40%	X
ondition	Non-preferred brand drugs		\$75	X	40%	X
ondition	Specialty drugs		30%	Х	40%	X
Outpatient	Facility fee (e.g., ASC)		30%	X	40%	Х
urgery	Physician/surgeon fees		30%	X	40%	X
	Emergency room services (v	vaived if admitted)	\$300	X	40%	X
	Emergency medical transport	rtation	\$300	X	40%	X
Need immediate attention	Urgent care		\$120	After 1st 3 non- preventive visits	40%	х
Insuital atou	Facility fee (e.g., hospital roo	om)	30%	X	40%	X
lospital stay	Physician/surgeon fee		30%	X	40%	Х
	Mental/Behavioral health ou	tpatient services	\$60	After 1st 3 non- preventive visits	40%	X
Mental health, ehavioral health,	Mental/Behavioral health inpatient services		30%	Х	40%	Х
or substance abuse needs	Substance use disorder outp	patient services	\$60	After 1st 3 non- preventive visits	40%	Х
	Substance use disorder inpa	atient services	30%	Х	40%	Х
	Prenatal care and preconcer	otion visits	No cost share		No cost share	
regnancy	Delivery and all inpatient	Hospital	30%	Х	40%	Х
	services	Professional	30%	X	40%	X
	Home health care		30%	X	40%	X
	Rehabilitation services		30%	X	40%	Х
lelp recovering	Habilitation services		30%	X	40%	X
r other special ealth needs	Skilled nursing care		30%	Х	40%	Х
	Durable medical equipment		30%	Х	40%	Х
	Hospice service		No cost share	X	No cost share	X
			0%		0%	· · · · · · · · · · · · · · · · · · ·
	Glasses					
	Dental check-up - Preventive Dental Basic Services		Pediatric Denta		Pediatric Denta	
Child needs dental or eye care	Dental check-up - Preventive and Diagnostic		1 pair per year		1 pair per yea	nta

Notes

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COST SHARING AMOUNTS DESCRIBE THE ENROLLEE'S OUT OF POCKET COSTS	Catastrophic Plan	
7/18/2013		
Actuarial Value - Final AV Calculator	60.4%	
Overall deductible	\$6,350 integrated Med/Rx	
Other deductibles for specific services		
Medical	N/A	
Brand Drugs	N/A	
Dental	See attachment	
Out-of-pocket limit on expenses	\$6,350	

Out-oi-pocket iiii	it on expenses		φ0,33	······
Common Medical Event	Service Ty	/pe	Member Cost Share	Deductible Applies
				After 1st 3
	Primary care visit to treat an in	niury or illness (see		non-
Visit to a health	footnote)	J J	0%	preventive
care provider's	# 1		PAGE AND ADDRESS OF THE PAGE A	visits
office or clinic	Specialist visit		0%	X
	Other practitioner office visit		0%	Х
	Preventive care/ screening/ in	nmunization	No cost share	
	Laboratory Tests		0%	Х
Tests	X-rays and Diagnostic Imagin	g	0%	X
	Imaging (CT/PET scans, MRI	s)	0%	X
Deuga to troot	Generic drugs		0%	Х
Drugs to treat illness or	Preferred brand drugs		0%	Х
condition	Non-preferred brand drugs		0%	Х
condition	Specialty drugs		0%	Х
Outpatient	Facility fee (e.g., ASC)		0%	X
surgery	Physician/surgeon fees		0%	X
	Emergency room services (wa	aived if admitted)	0%	Х
	Emergency medical transports		0%	Х
Need immediate				After 1st 3
attention	Hannatara			non-
	Urgent care	0%	preventive	
			visits	
	Facility fee (e.g., hospital roor	n)	0%	X
Hospital stay	Physician/surgeon fee		0%	Х
				After 1st 3
			non-	
	Mental/Behavioral health outp	0%	preventive	
			2000	visits
Mental health,	M - 4-1/D -1			
behavioral health,	Mental/Behavioral health inpa	tient services	0%	Х
or substance				After 1st 3
abuse needs	0.1-1			non-
	Substance use disorder outpa	0%	preventive	
			and the second	visits
	C. hataaaa diaaada iaaa k			.,
	Substance use disorder inpati	ent services	0%	Х
	Prenatal care and preconcept	ion visits	No cost share	
Pregnancy	Delivery and all inpatient	Hospital	0%	Х
	services	Professional	0%	Х
	Home health care		0%	Х
	Rehabilitation services		0%	X
Help recovering	Habilitation services		0%	Х
or other special	Chillad access		00/	17
health needs	Skilled nursing care		0%	Х
	Durable medical equipment		0%	Х
	Hospice service		No cost share	X
	Eye exam (deductible waived)	0%	
Obild acada	Glasses	***************************************	1 pair per year	
Child needs	Dental check-up - Preventive	and Diagnostic		
dental or eye care	Dental Basic Services	***************************************	Pediatric Denta	
	Dental Restorative and Orthogonal	dontia Sarvicas	- Plan Design	attached

Notes

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California Health Benefit Exchange Standard Pediatric Dental Essential Health Benefits Plan Design Revised March 15, 2013

Procedure Categories	PPO High	PPO Low	
	Plan	Pays:	
Diagnostic & Preventive (D&P)	100%	100%	
X-rays, Exams, Cleanings			
Sealants			
Office Visit	n/a	n/a	
Basic Services - Basic Restorative	80%	50%	
Major Services - Crowns & Casts,			
Prosthodontics, Endodontics, Periodontics, Oral	50%	50%	
Surgery			
	Enrollee Pays:		
Orthodontics (Medically Necessary)	50%	50%	
	\$50	\$60	
Deductible	(not		
	applied		
	to D&P)	services)	
A served Bifordinasses	NI.	NI	
Annual Maximum	None	None	
OOP Maximum	\$1,000	55555	
Waiting Periods (Major & Ortho)	None	None	
1	I		
Actuarial Value (AV)	86%	72%	

DHMO High	DHMO Low
Enrolle	e Pays:
\$0	\$0
\$0	\$20
\$40 ³	\$95 ³
\$365 ⁴	\$365 ⁴
\$1,000	\$1,000
None	None
None	None
\$1,000	\$1,000
None	None
87%	72%

Notes:

- 1. Actuarial values are based on pediatric claims experience.
- 2. Orthodontics includes medically-necessary orthodontia only.
- 3. DHMO Basic Services copayments vary by procedure within this category. Using a statistically significant set of claims data, the plan's average co-pay charged for procedures in this category cannot exceed the stated amount.
- 4. DHMO Major Services copayments vary by procedure within this category. Using a statistically significant set of claims data, the plan's average co-pay charged for procedures in this category cannot exceed the stated amount.